Medical Records Release Form

This form is posted on our website www.kidseyecare.net

PEDIATRIC OPHTHALMOLOGY ASSOCIATES

Caring For the Vision of Our Future

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Release of Medical Records For the Following Patient (s):

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Letter authorizes Pediatric Ophthalmology Associates to provide a copy of my /my child's medical records:

☐ Record of Care from _____ (date) to _____ (date)

☐ Child's Complete Medical Record

I hereby request that my/my child's medical records be released to:

Name: _____

Fax# _____

Phone #: _____

Address: _____

City, State, Zip: _____

Purpose for release of records:

☐ Referring Specialist/Doctor ☐ Personal Records/ Moving ☐ Changing Physicians

☐ Other: _____

I understand that Pediatric Ophthalmology Associates will provide this information within 15 business days after date of receipt of the written consent for release and that a reasonable fee for furnishing this information may be charged.

Patient or Guardian: _____ Relationship to Child: _____

Phone:_____ Address: _____

Signature: _____ Date: _____